Encore Medical Staffing, Inc.

INDEPENDENT CONTRACTOR INFORMATION

Instructions: This form is a professional document and must be completed with true and accurate information. The information provided may, upon request, be furnished to those facilities receiving services from a health professional through ***Encore Medical Staffing.*** Please fill in all blanks.

Name: ______________________________ _________ ______________________________
First MI Last

Address: ____

City / State: ____ **Zip Code:** ________________

Home Phone: ___________________________ **Cell Phone:** ___________________________

Email Address: ____

Please Check One: **Registered Nurse _____ Licensed Practical Nurse ____Geriatric Nurses Asst. ____**
Certified Nurses Assistant ________ Home Health Aide _______
Home Sitter ______ Physical Therapist _______ Speech Therapist ______
Occupational Therapist _______ Respiratory Therapist _______
Phlebotomist______ Travel Assignments _______ Other ____________________

Preferred Shifts: ______ Referred By: ____________________________________

Employment History (Beginning with most recent)

Name of Company: ____

Address: ____

City / State / Zip Code: ____

Phone Number: ____

Date Worked From: ________________________ **To:** _________________________

Position / Duties: ____

Name of Company: ____

Address: ____

City / State / Zip Code: ____

Phone Number: ____

Date Worked From: ______________________ To: _________________________

Position / Duties: ____

<u>Education</u>

High School: ___________________________ Yr. Grad: ____________________

City / State: ____________________________ Degree: ______________________

College: _______________________________ Yr. Grad: ____________________

City / State: ____________________________ Degree: ______________________

I agree to hold harmless *Encore Medical Staffing*, if injured on the job as an Independent Contractor.

I assume the risk and understand that I am not covered under workers compensation or general and professional liability with *Encore Medical Staffing* insurances.

<u>Licensure</u>

State: ____________________ License #: ______________ Expires: _________

State: ____________________ License #: ______________ Expires: _________

Malpractice Insurance Company: ____

Policy #: _________________________ Expiration Date: ____________________

____ ______________________

Independent Contractor **Date**

MEDICAL / SURGICAL SKILLS CHEKCLIST

1 – NO EXPERIENCE
2 – SOME EXPERIENCE (Require assistance / supervision)
3 – EXPERIENCED (Need initial review, then can perform independently)
4 – VERY EXPERIENCED (Can perform well independently)

Please select the column that most accurately describes your experience level.

EXPERIENCE LEVEL	**1**	**2**	**3**	**4**	**EXPERIENCE LEVEL**	**1**	**2**	**3**	**4**
NEUROLOGY:					**CARDIOVASCULAR: (Cont.)**				
Neurological Assessment:					Maintenance				
Neuro Vital Signs					Obtaining 12 - Lead EKG				
Glascow Coma Scale					Cardiopulmonary Resuscitation				
Levels of Consciousness					Defibrillation / Cardioversion				
Seizure Precautions					Care of Patient With:				
Care of Patient With:					Acute MI				
Seizures					Pre - Post Cardiac Catheter				
CVA					Post Cardiac Surgery				
Spinal Cord Injury					Post Thoracic Surgery				
Spinal Surgery					CHF				
Craniotomy					**RESPIRATORY:**				
Neuromuscular Disease					Respiratory Assessment				
Pre & Post Mylogram					Auscultation				
Pre & Post Cerebral Angiogram					Airway Care & Maintenance:				
Crutchfield Tongs					Oral Airway				
Halo Traction					Nasal Airway				
Roto Rest Bed					Endotracheal Tube				
Stryker Frame					Tracheostomy				
Skin & Skeletal Traction					Suctioning:				
Assist with Lumbar Puncture					Oral Pharyngeal				
Maintenance of Skin					Nasal Tracheal				
CARDIOVASCULAR:					Tracheal Via ET Tube				
Cardiovascular Assessment					Tracheal Via Trach				
Auscultation					Incentive Spirometry				
Arrhythmia Interpretation					Chest Physio Therapy				
Telemetry					Care of Patient With:				
Initiation					AIDS				

EXPERIENCE LEVEL	1	2	3	4	EXPERIENCE LEVEL	1	2	3	4
RESPIRATORY: (Cont.)					**GASTROINTESTINAL: (Cont.)**				
Pneumonia					Feeding Tubes				
COPD					Duo Tube				
Lung CA					Keo Feed				
Chest Tubes					Maintenance of Enteral Nutrition:				
Emersion Suction					Continuous				
Pleur - Evac Suction					Intermittent				
Maintenance of Oxygen Therapy:					**GENITOURINARY / RENAL:**				
Nasal Cannula					GU Assessment:				
Aerosol Mask					Palpation				
Venti Mask					Interpretation of Lab Values				
Trach Collar					Insertion of Foley Catheter				
T - Piece					Male				
Ventilators					Female				
Types:					Care of Patient With:				
Ambu Bag					Supra Pubic Catheters				
Assist With:					3-Way Foley				
Arterial Puncture for ABG					GU Irrigations				
Insertion / Removal Chest Tubes					Continuous				
Thorocentesis					Intermittent				
Changing Tracheostomy Tubes					AV Fistulas				
GASTROINTESTINAL:					Shunts				
Gastrointestinal Assessment:					Quinton Catheters				
Auscultation					**INTERVENOUS THERAPY:**				
Palpation					Insertion and Care Of:				
Care of the Patient With:					Heparin Locks				
Abdominal Distention					Peripheral IV				
GI Bleed					Assist With and Care Of:				
Multiple Abdominal Wounds & Drains					Central Lines				
Colostomy					Triple Lumen				
Gastrostomy					Care of the Patient With:				
Jejunostomy					Implantable Venous Access Devices				
T -Tube					Broviac				
Hemovac					Groshong				
Dehiscence					Porta Cath				
Nasogastric Tubes					Other				
Salem Sump									
Levine Tube									

EXPERIENCE LEVEL	1	2	3	4	EXPERIENCE LEVEL	1	2	3	4
MED ADMINISTRATION:					**NURSING ADMINISTRATION:**				
Oral					Charge Nurse				
IM					Patient/Family Teaching				
IVP									
IV Piggy Back									
IV Admixture									
Unit Dose									
Administration for 1-10 Patients									
Administration for 10-20 Patients									
Pediatric Conversions									
Knowledge of Chemotherapy:									
Preparation									
Administration									
Disposal									
Administration of Blood and Blood Products									
Experience with the Following:									
Aminophylline									
Dopamine									
Hyperalimentation									
Intralipid Administration									
Lidocaine									
Lasix									
Lanoxin									
Heparin									
Insulin									

I ATTEST THAT THE INFORMATION CONTAINED ABOVE IS TRUE AND ACCURATE.

______________________________ ______________________________

Independent Contractor **Date**

______________________________ ______________________________

Encore Staff **Date**

CONSENT FOR CRIMINAL BACKGROUND CHECK WITH INVOICE PAYMENT REDUCTION

This authorization will allow you to release to Encore Medical Staffing or its representatives, all information you may have regarding any criminal **convictions** of any nature whatsoever regarding the individual named below. This also gives approval to reduce my first invoice by $_____________ dollars to cover the cost of my background check. I also have the right to have a copy of this background check.

PLEASE PRINT CLEARLY

Full Legal Name: ____

Address: ____

City: ______________________ Country: _____________________________

State: ______________________ Zip Code: __________________________

Date of Birth: _________________ Race: ___________ Sex: _____________

Social Security Number: ____

(Very Clear Numbers)

X ____

Authorized Independent Contractor

Driver's License Verified: ____

Date **Encore Initials**

Social Security Card Verified: ____

Date **Encore Initials**

DRIVERS LICENSE VERIFICATION

INDEPENDENT CONTRACTOR_______________________________

LICENSE #____

EXPIRATION DATE____

DATE VERIFIED____

BY____

Current Licensure, CPR Certification Card, and Drivers License

Please be sure to include a copy of your Current Licensure, CPR Certification Information, and Drivers License.

www.encoremedicalstaffing.com

CURRENT TB / PPD VERIFICATION

Independent Contractor Name: ____

Date of Injection: ____

Site of Injection: ____

Given By: ____

TO BE READ BY DESIGNATED MEDICAL PERSONNEL 48 – 72 HOURS AFTER INJECTION!

Date Read: ____

Read By: ____

Results: ____

NOTE: IF "POSITIVE"…INCLUDE MM INDURATION.

IF SKIN TEST IS POSITIVE (10 MM OR LARGER), REFER TO FAMILY PHYSICIAN FOR CHEST X-RAY.

Comments: ____

____

____

HEPATITIS B VACCINE VERIFICATION

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine from a physician or other facility of my choice and at my own expense. If I have already received the Hepatitis B vaccine or receive the vaccine in the future, I agree to provide the written documentation to verify the same to Encore Medical Staffing if I will continue to contract my services through EMS as an Independent Contractor.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from a physician or other facility of my choice and at my own expense.

With my **signature** in the appropriate space below, I hereby agree that I decline the Hepatitis B vaccine or have or will provide the written documentation to verify that I have received the Hepatitis B vaccination series.

I decline the Hepatitis B vaccine.

____

I have received the Hepatitis B vaccine. ______________________________

I will provide verification of the Hepatitis B vaccine. _____________________

I will take the Hepatitis B vaccine and provide that info to EMSI. ___________

____

Independent Contractor Signature **Date**

HIPAA FORM

I have been formally instructed regarding the policies and procedures of ***Encore Medical Staffing*** and HIPAA regulations.

I understand that from time to time, I may be required to handle material of a confidential nature. I will treat as confidential anything that is not common knowledge, or has not been published, which includes patient's personal health information. I will respect the trust ***Encore Medical Staffing*** has placed in me by handling all such information in a careful and discrete manner. I will never divulge protected patient information, or company information to outsiders, including the media and/or government representatives without prior approval from my supervisor. I will contact my supervisor when I have any doubt about any matters relating to confidentiality of materials.

I understand that confidential information included, but not limited to the following examples:

Compensation Data
Computer Processes
Computer Programs & Codes
Customer List
Customer Preferences
Financial Information
Marketing Strategies
Technological Data
Patient Information

I also certify that I am aware of all OSHA and HIPPA guidelines and will be asked to sign a non-disclosure agreement as a condition of my employment.

__________________________________ ____________________________
Independent Contractor | Date

__________________________________ ____________________________
Encore Representative | Date

OSHA FORM

Encore Medical Staffing has in place an education program to train healthcare workers to be knowledgeable and understand the OSHA standards CFR 1910:1030 and JCAHO requirements of safety.

I have demonstrated competency in the following areas as evidence by competency exams on file and available in my personnel record:

A. Fire Safety

B. Body Mechanics

C. Chemical Hazards/MSDS

D. CDC Guidelines & Infection Control

E. Bloodborne Pathogens, Universal Precautions, Aids, & TB

F. Venipuncture Assessment

G. Pharmacology Exam

H. HIPAA COMPLIANCE

Independent Contractor: ________________________________ Date: ______________

PAYMENT INSTRUCTION FORM

I, the undersigned, do hereby instruct and direct EMS to pay all sums due to me for services rendered as an Independent Contractor on the following basis:

Daily ___________
Weekly _________
Bi-Weekly_______
Monthly ________

I understand that I am an Independent Contractor and not an employee of EMS and that it is my desire that EMS regard the information signed by me on the daily time slip as accurate. I understand that I have the complete authority and power to elect to be paid on a basis purely of my own control and direction. I further understand that EMS will issue a check to me for sums due within two working days after the end of the period elected above.

I understand that I am self-employed and am responsible for filing and paying my own federal, Social Security, and F.I.C.A. taxes. I further understand that EMS is not responsible for my tax liability for fees received while sub-contracting my services through EMS.

I authorize EMS to release my check to the following named persons:

1. ______________________________
2. ______________________________

I understand and agree that this release will remain valid until I notify EMS in writing, either by mail or personally hand deliver to EMS a written statement canceling this release. I further agree that I will hold EMS harmless for the monies due me if misappropriated by the above named individuals.

I would like my check mailed to me. (Initial if applicable.) _________

Independent Contractor: ______________________________

Date: ____

Encore Medical Staffing, Inc.

TUBERCULOSIS (TB) TEST

NAME: ____ DATE: _____________

1. What causes tuberculosis?

a. Tuberculin
b. Isoniazid
c. Mycobacterium Tuberculosis

2. Tuberculosis is most commonly found in the:

a. Skin
b. Kidneys
c. Lungs

3. Usually, tuberculosis is screened by first using a:

a. Chest X-Ray
b. Skin Test
c. Sputum Smear

4. Multi-drug resistant tuberculosis:

a. Cannot be cured with drugs
b. Resists more than one drug
c. Can be cured with any TB drug

5. Signs and Symptoms of TB are:

a. Prolonged cough/fatigue
b. Loss of appetite/ Weight loss
c. Fever/night sweats
d. All of the above

NEW CENTERS FOR DISEASE CONTROL (CDC) GUIDELINES

1. The definition of the new "Standard Precautions" includes:

a. The use of gloves for contact with blood; all body fluids, secretions, and excretions

b. The use of gloves for contact with mucous membranes and non-intact skin

c. Hand washing: each time gloves removed, after contact with possibly contaminated equipment, and between patient contact

d. All of the above

2. Standard Precautions includes changing gloves at the following times:

a. Just before contact with mucous membranes and non-intact skin

b. When gloves become excessively contaminated

c. At the end of the day

d. A and B

3. The following is true regarding hand washing:

a. Hands should be washed even if gloves are worn during contact

b. Hand should be washed only if gloves are not worn

c. A plain, non-antimicrobial soap is recommended

d. A and C

4. The following is true regarding personal protective equipment:

a. The health care worker is responsible for selecting and wearing the proper protective equipment

b. Standard equipment includes: gown, gloves, masks, and goggles

c. A surgical mask and face shield should be worn when a splash from secretions is likely

d. All of the above

5. The following is true regarding "Airborne Precautions":

a. Used for organisms spread by tiny pathogens in the air

b. Airborne pathogens are lightweight, can travel long distances on dust and moisture in air currents

c. The door to patient rooms must be closed at all times

d. All of the above

VENIPUNCTURE ASSESSMENT TEST

1. **Select the most appropriate method to fill a vein:**
   a. Hydration, gravity, cold soak to site, slapping the vein
   b. Tourniquet, gentle tapping, warm compresses
   c. Leave patient's hand open and limp, dehydrate slightly, apply friction rub to vein
   d. All of the above

2. **What clinical s/s might you observe if the tourniquet is too tight?**
   a. Blanching, cyanosis
   b. Pain, inability to draw blood
   c. Numbness, tingling, prickly sensations
   d. All of the above

3. **What gauge needles are commonly used for drawing blood?**
   a. 14, 16, 18
   b. 20, 21, 22

4. **What is extravasation?**
   a. A rare form of coagulopathy
   b. A terminal symptom in leukemia
   c. Escape of blood from a vessel into the tissue
   d. When vein is hard

5. **What patients are at increased risk for extravasation?**
   a. Elderly
   b. Infants
   c. Diabetics
   d. Those taking anticoagulants
   e. All of the above

FIRE SAFETY

1. While escaping a fire, close as many doors as possible to prevent the fire's spread.

True False

2. You should get down and keep low because smoke and gases rise and the air will be cleaner near the floor.

True False

3. Stop, drop and roll if your clothing is on fire

True False

4. When leaving a burning building you should:

a. Keep contact with the wall

b. Use handrails to go down the stairs

c. Test doors with the backs of your hands before entering room; if it is hot use another route

d. All of the above

5. After escaping the building you should:

a. Move away from it and cross the street

b. Stay out of the way of rescue personnel and equipment

c. Leave and go home as soon as possible

d. A, B, and C

e. A and B ONLY

Encore Medical Staffing, Inc.

BLOODBORNE PATHOGENS / UNIVERSAL PRECAUTIONS TEST

NAME: ____ DATE: ______________

1. HIV means HEPATITIS IMMUNODEFICIENCY VIRUS. T F

2. HBV means HEPATITIS B VIRUS. T F

3. HIV can cause AIDS. T F

4. HBV causes LIVER INFLAMMATION. T F

5. Protective equipment such as gloves, masks, and face shields must be provided by the worker at his/her own expense. T F

6. "UNIVERSAL PRECAUTIONS" is a plan that treats all blood and body fluids in the workplace as if they are contaminated by bloodborne pathogens. T F

7. Sweat is a body fluid the "UNIVERSAL PRECAUTIONS" plan requires you to treat as contaminated bloodborne pathogens. T F

8. All workers who have routine exposure to blood or other potentially infectious materials should receive the Hepatitis B vaccine at no cost to themselves. T F

9. The Hepatitis B vaccine is given in three doses over a 6 month period. T F

10. There is no vaccine for the prevention of HIV infection. T F

11. An employee who is covered under the OSHA Bloodborne Pathogens Standard to receive a Hepatitis B vaccine may choose to refuse it if he/she signs a declination form. T F

12. Drinking coffee is forbidden in areas where there may be exposure to bloodborne pathogens. T F

13. Hand washing with soap and warm water is an important example of work practice control. T F

14. If you get contaminated blood or body fluids in your eyes, rinse them out with water and report the incident to your employer. T F

15. More healthcare workers contract Hepatitis than AIDS. T F

16. If a healthcare worker leaves the examination room to take a phone call, his/her gloves should be changed before touching the same patient again. T F

17. Gowns are worn to protect the healthcare workers skin and street clothing from body fluid. T F

Encore Medical Staffing, Inc.

MATERIAL SAFETY DATA SHEETS TEST (MSDS)

NAME: ______________________________________ DATE: ____________

Instructions: Read each question. Circle "T" for true and "F" for false.

1. Each employee has the right to receive proper health and safety training. T F

2. The hazardous chemicals contained in each product are listed on the Material Safety Data Sheet (MSDS). T F

3. A Hazardous Chemical Substance List is prepared for room/location in the facility where hazardous supplies are kept. T F

4. An employee should not use a hazardous product unless an MSDS is available and the employee has reviewed it. T F

5. A hazardous product not in its original container requires a label listing the product's manufacturer, chemical name, dilution, common name and target organs affected. T F

6. It is not necessary for all work-related accidents or health/safety incidents affecting an employee to be listed in his/her OSHA records. T F

7. The only accidents, which must be reported to the Safety Officer, are those involving contact with blood or body fluids. T F

8. Food and infectious materials may be stored in the same refrigerator, provided that a hazard warning label is placed on the front of the refrigerator. T F

9. Non-hazardous products like soap solutions and distilled water do not require an extensive label information as hazardous products. T F

10. Infectious waste bags can be any color and do not need a biohazard symbol as long as they are in a closed container. T F

11. New employees must be familiar with all the chemical products they will use before they can begin work at their job site. T F

12. Cat litter should not be used for soaking up spills because it produces too much dust. T F

13. A can of Ajax or other kitchen cleanser requires an MSD Sheet. T F

14. An employee must receive MSDS information before using a new hazardous product. T F

15. An employee may be dismissed from the job if he/she fails to comply with the employer's safety and health policies. T F

16. The MSD Sheets are kept in a location easily accessible by all health facility personnel during working hours. T F

Encore Medical Staffing, Inc.

BODY MECHANICS TEST

NAME: ____ DATE: _______________

1. **WHEN LIFTING**:

A. hold load away B. hold load close C. does not matter

2. **BASIC TRANSFER PROCEDURES ARE**:

A. always do the same way B. adapt to the conditions C. none are necessary

3. **TO TRANSFER TO SIDE OF BED**:

A. push B. reach under patient and pull C. Pull patient's arm

4. **TO TRANSFER TO HEAD OF BEAD:**

A. keep patient's knees flat B. raise patient's knees C. doesn't matter about knees

5. **TO TURN PATIENT ON SIDE:**

A. push B. reach over; pull shoulder-hip C. tilt bed

6. **TO ASSIST FOR SIT-UP:**

A. pull patient's arm B. patient hugs your neck C. raise their body while lowering their legs

7. **TO ASSIST FOR STAND-UP:**

A. get back, then reach out B. get close with knees bent C. either way you want

8. **TO ASSIST WITH SITTING:**

A. patient hugs your neck B. patient leans on chair arms C. either way you want

9. **TO ASSIST WITH WALKING, YOU STAND AT:**

A. patient’s weak side B. patient’s strong side C. either way you want

10. **TO ASSIST WITH A HEAVY PATIENT:**

A. get help or and mechanical aid B. try very hard C. don’t do anything

INDEMNITY / HOLD HARMLESS AGREEMENT

This is an agreement between Encore Medical Staffing, (hereafter "EMS") and the personnel (hereafter referred to as the "undersigned" or "personnel") it places as contract workers in healthcare / provider facilities. EMS's mission is to place needed personnel into various healthcare facilities. At all times, when personnel is traveling to, performing work at, and / or traveling away from the healthcare facility, the undersigned person is an Independent Contractor as defined under SC R.S. 23: 1021 (7).

EMS does not exercise any control or supervision whatsoever over said personnel when they are performing their employment duties at the healthcare facility. Personnel are under the supervision and control of the healthcare facility where he or she is working at all times.

EMS suggests that Independent Contractors should maintain their own medical and disability insurance at all times.

As such, EMS and ______________________, the undersigned, agree that in the event of an accident of any kind or cause, EMS will not be held responsible or liable for damages by the undersigned in tort, workers' compensation, or under any other avenue of compensation. The undersigned agrees to indemnify EMS against liability and assume all risks associated his or her duties while working as an Independent Contractor in any healthcare facility where he or she is placed.

This agreement will remain in effect unless the undersigned notifies EMS in writing that he or she wishes to terminate the agreement, at which time the undersigned will be ineligible for placement services from EMS.

______________________________	______________________________
Independent Contractor / Undersigned	Witness

STATEMENT OF INDEPENDENT CONTRACTOR HEALTH STATUS AND INJURY HISTORY

Please circle all the following that apply or have applied:

1. **Reactions to medications**
2. **Skin rashes or eczema**
3. **Back trouble**
4. **Back injury**
5. **Back surgery**
6. **Back pain on lifting**
7. **Knee surgery**
8. **Swollen joints**
9. **Rheumatism or arthritis**
10. **Dislocated shoulder**
11. **Fracture of a bone**
12. **Any other type of injury**

Work related injury claim within the past five years? _______________

____

Allergies ____

Comments ____

Emergency Contact: ____

Telephone Number: ____

_____________________________________　　　　　　_______________

Independent Contractor Signature　　　　　　　　　　**Date**

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type — See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ---------------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,